SERFF Tracking Number:	*STFL-126339540*	*State:*	*Arkansas*
Filing Company:	*State Farm Life Insurance Company*	*State Tracking Number:*	*43756*
Company Tracking Number:	*SFL1000704*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life_FE Applications*		
Project Name/Number:	*Life_FE Applications/Life_FE Applications*		

Filing at a Glance

Company: State Farm Life Insurance Company

Product Name: Life_FE Applications	SERFF Tr Num: STFL-126339540	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 43756
Sub-TOI: L08.000 Life - Other	Co Tr Num: SFL1000704	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Rhonda Brackman	Disposition Date: 10/13/2009
	Date Submitted: 10/12/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 04/26/2010		Implementation Date:

State Filing Description:

General Information

Project Name: Life_FE Applications
Project Number: Life_FE Applications
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/13/2009

Deemer Date:
Submitted By: Rhonda Brackman
Filing Description:
NAIC # 69108
FEIN #37-0533090

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 10/13/2009
Created By: Rhonda Brackman
Corresponding Filing Tracking Number:

Dear Sir or Madam:

Enclosed for your consideration are the following new individual life insurance application forms:

Form # Form Name
1000704 AR Application for Individual Life Insurance

SERFF Tracking Number:	*STFL-126339540*	*State:*	*Arkansas*
Filing Company:	*State Farm Life Insurance Company*	*State Tracking Number:*	*43756*
Company Tracking Number:	*SFL1000704*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life_FE Applications*		
Project Name/Number:	*Life_FE Applications/Life_FE Applications*		

1000717 AR Application for $10,000 Individual Whole Life Insurance Policy

Form 1000704 AR will replace form 121173.1, which was approved by your Department on May 13, 2008.

Form 1000717 AR will replace form 121170, which was approved by your Department on February 14, 2005.

The revisions to Form 1000704 AR are as follows:

„X The format of the application has been changed.
„X Question 22 is a new question; the remaining questions have been renumbered.
„X Questions 6, 9, 23, and 25 have been revised.
„X The ¡§AGREEMENTS¡¨ section has been expanded.

The revisions to Form 1000717 AR are as follows:

„X The format of the application has been changed.
„X Question 3 is a new question; the remaining questions have been renumbered.
„X Questions 9-14 have been revised.
„X The ¡§AGREEMENTS¡¨ section has been expanded.

The formatted application can be completed in paper or electronically in the agent¡¦s office which will allow an electronic digitized signature by the customer.

These forms will be marketed exclusively through State Farm agents.

The effective date for these new forms will be April 26, 2010.

Company and Contact

Filing Contact Information

Rhonda Brackman, Analyst - Contracts & Compliance	rhonda.brackman.aim3@statefarm.com	
1 State Farm Plaza	309-766-6896 [Phone]	
Bloomington, IL 61710-0001	309-766-8483 [FAX]	

Filing Company Information

State Farm Life Insurance Company	CoCode: 69108	State of Domicile: Illinois
1 State Farm Plaza	Group Code:	Company Type:
Bloomington, IL 61710-0001	Group Name:	State ID Number:

SERFF Tracking Number:	*STFL-126339540*	*State:*	*Arkansas*
Filing Company:	*State Farm Life Insurance Company*	*State Tracking Number:*	*43756*
Company Tracking Number:	*SFL1000704*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life_FE Applications*		
Project Name/Number:	*Life_FE Applications/Life_FE Applications*		

(309) 766-4541 ext. [Phone] FEIN Number: 37-0533090

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	2 forms @ $50 = $100 (EFT Voucher ID #14273666)
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
State Farm Life Insurance Company	$100.00	10/12/2009	31219021

SERFF Tracking Number:	*STFL-126339540*	*State:*	*Arkansas*
Filing Company:	*State Farm Life Insurance Company*	*State Tracking Number:*	*43756*
Company Tracking Number:	*SFL1000704*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life_FE Applications*		
Project Name/Number:	*Life_FE Applications/Life_FE Applications*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/13/2009	10/13/2009

SERFF Tracking Number:	*STFL-126339540*	*State:*	*Arkansas*
Filing Company:	*State Farm Life Insurance Company*	*State Tracking Number:*	*43756*
Company Tracking Number:	*SFL1000704*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life_FE Applications*		
Project Name/Number:	*Life_FE Applications/Life_FE Applications*		

Disposition

Disposition Date: 10/13/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*STFL-126339540*	*State:*	*Arkansas*
Filing Company:	*State Farm Life Insurance Company*	*State Tracking Number:*	*43756*
Company Tracking Number:	*SFL1000704*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life_FE Applications*		
Project Name/Number:	*Life_FE Applications/Life_FE Applications*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Fee Schedule		No
Form	Application for Individual Life Insurance		No
Form	Application for $10,000 Individual Whole Life Insurance Policy		No

SERFF Tracking Number:	*STFL-126339540*	*State:*	*Arkansas*
Filing Company:	*State Farm Life Insurance Company*	*State Tracking Number:*	*43756*
Company Tracking Number:	*SFL1000704*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life_FE Applications*		
Project Name/Number:	*Life_FE Applications/Life_FE Applications*		

Form Schedule

Lead Form Number: 1000704

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	1000704 AR	Application/ Enrollment Form	Application for Individual Life Insurance	Initial			J2EE Life App 1000704 AR_138306_ DOI [Bracketed].pdf
	1000717 AR	Application/ Enrollment Form	Application for $10,000 Individual Whole Life Insurance Policy	Initial			J2EE FE App 1000717 AR_138321 [Bracketed].pdf

State Farm Life Insurance Company
One State Farm Plaza, Bloomington, IL 61710-0001

Doc Type: **01** Check Digit

Application for Individual Life Insurance

1. Type of Application *(Check one)*

a. [●] New Business

b. ○ Change of Plan/Added Benefits ○ Universal Life Increase Existing Plan Number(s):

○ Term Conversion with Increase in Amount ○ Select Term Re-entry

2. Proposed Insured 1 *(Print name in full)*

a. [●] Mr [○] Ms

Last Name	First Name	Middle Initial
[Doe]	[John]	[J]

b.

Mailing Address	City	State	ZIP Code
[123 Main St.]	[Bloomington]	[IL]	[61701]

c.

Social Security or Tax Identification Number	Driver's License Number	State	Sex	Birth Date (mm/dd/yyyy)	Age
[000-00-0000]	[D000-0000-0000]	[IL]	[M]	[08-22-1974]	[35]

d.

Marital Status	Height	Weight	State of Birth	United States or Canadian Citizen?	Yes	No
[Married]	[5 10]	[195]	[IL]		[●]	[○]

e.

Occupation	Employer's Name
[Attorney]	[Self]

Do job duties involve work in one of the following occupation categories: amusement, sports, construction, explosives, diving, liquor, logging, mining, gas, or oil? *(If yes, explain exact duties.)* Yes [○] No [⊗]

f.

3. Proposed Insured 2 *(Additional Insured or Payor, print name in full)*

a. ○ Mr ○ Ms

Last Name	First Name	Middle Initial

b.

Social Security or Tax Identification Number	Driver's License Number	State	Sex	Birth Date (mm/dd/yyyy)	Age

c.

Marital Status	Height	Weight	State of Birth	United States or Canadian Citizen?	Yes	No
					○	○

d.

Occupation	Employer's Name

Do job duties involve work in one of the following occupation categories: amusement, sports, construction, explosives, diving, liquor, logging, mining, gas, or oil? *(If yes, explain exact duties.)* Yes ○ No ○

e.

4. Applicant/Owner *(Complete 4 if not Proposed Insured 1, print name in full)*

a.

Last Name	First Name	Middle Initial	Social Security or Tax Identification Number
[Doe]	[Jane]	[A]	[000-00-0000]

b.

Mailing Address	City	State	ZIP Code
[123 Main St.]	[Bloomington]	[IL]	[61701]

Successor Owner *(Required unless the Applicant/Owner is a **Trust** or **Corporation**)*

c.

Last Name	First Name	Middle Initial
[Doe]	[Jill]	[A]

5. Complete 5 if Proposed Insured is under age 16

a. Is Proposed Insured to be Owner at and after age 21? Yes ○ No ○

b. Give amount of insurance in force on: *(If none, so indicate.)*
Father $ Mother $

6. Coverages Applied For *(Do not complete 6-8 if applying for Universal Life.)*

a. Amount Applied For: $ [25,000]

Basic Plan coverage applied for:

[◉] Whole Life	[◯] Term to Age 95 - 10	[◯] 5 Year Term	[◯] Decreasing Term - 15
[◯] 15 Pay Life	[◯] Term to Age 95 - 20	[◯] Return of Premium Term - 20	[◯] Decreasing Term - 30
[◯] Single Premium Life	[◯] Term to Age 95 - 30	[◯] Return of Premium Term - 30	

b. Riders/Benefits applied for: *(Check Ratebook for availability of riders.)*

[ ] Waiver of Premium (PI 1 only) ◯ Yes ◯ No			
[ ] Payor (Complete PI 2)			
[ ] Guaranteed Insurability Option $ _____		[ ] Decreasing Term - 15 (PI 1) $ _____	
[ ] Children's Term Rider _____ Units		[ ] Decreasing Term - 15 (PI 2) $ _____	
[ ] 5 year Term (PI 1) $ _____		[ ] Decreasing Term - 30 (PI 1) $ _____	
[ ] 5 year Term (PI 2) $ _____		[ ] Decreasing Term - 30 (PI 2) $ _____	

c. Amount of premium submitted with Application: $ [436.75]

Mode of premium payment: [annual]

7. Dividend Option

If the dividend option chosen is not available or no option is chosen, policy provisions determine the option.

[◉] Paid-up Additions ◯ Accumulate ◯ Reduce Premium ◯ Cash

8. Complete if policy applied for has an APL provision.

	Yes	No
Do you want the Automatic Premium Loan provision to apply, if applicable?	[◯]	[◉]

9. Universal Life

a. Initial Basic Amount: $ _____

b. Death Benefit: *(Complete for new policy only.)*

If no option is chosen, policy provisions determine the option.

◯ Option 1 - Basic Amount ◯ Option 2 - Basic Amount plus Account Value

c. Riders/Benefits applied for: *(Check Ratebook for availability of riders.)*

Waiver of Monthly Deduction (PI 1 only) ◯ Yes ◯ No

☐ Guaranteed Insurability Option $ _____ ☐ Level Term (PI 2) $ _____

☐ Children's Term Rider _____ Units

d. Dividend Option:

If no option is chosen, policy provisions determine the option.

◯ Addition to Account Value ◯ Cash

e. Planned Premium:

Mode chosen: ◯ Annual

◯ SFPP Existing SFPP Account Number: _____

◯ Other Special Monthly: _____

Amount to be billed each payment date: $ _____

Amount of premium submitted with Application: $ _____

f. Increase in Basic Amount for Universal Life only: *(Do not complete for new policy.)* $ _____

10. Beneficiary Designation - Proposed Insured 1

Completion of this section will replace all previous rider and policy designations for this policy. If a Change of Plan or an addition in coverage, this designation will replace previous designations for this insured.

Primary Beneficiary - Full Name	Relationship
[Jane A. Doe]	[Spouse]
Successor Beneficiary - Full Name	**Relationship**
[Jill A. Doe]	[Child]

11. Beneficiary Designation - Proposed Insured 2

Complete for Additional Insured's rider only if the Beneficiary provision in the rider is NOT desired. If this section is completed, the Payment of Benefit provision of the policy will control rather than the Beneficiary provision of such rider. "Additional Insured" would be used in place of the "Insured". If a Change of Plan or an addition in coverage, this designation will replace previous designations for this insured.

Primary Beneficiary - Full Name	Relationship
Successor Beneficiary - Full Name	**Relationship**

12. Complete 12 if CTR applied for. *List children under age 18 (if none, so state)*

Last Name, First Name, MI *(If last name different, explain.)*	Relationship to Proposed Insured 1	Birthdate Month	Birthdate Day	Birthdate Year	Amount Now Insured For
					$

Complete 13-15 if CTR applied for OR Proposed Insured 1 is under age 16.

13. In the last 10 years, has Proposed Insured 1 or any children named in question 12, been diagnosed, treated, or been given advice by a member of the medical profession for: *(If yes, check all that apply and explain.)* Yes ◯ No ◯

- **a.** ☐ birth defect
- **b.** ☐ asthma
- **c.** ☐ kidney disease
- **d.** ☐ leukemia
- **e.** ☐ mental disorder
- **f.** ☐ seizure
- **g.** ☐ heart murmur
- **h.** ☐ cancer
- **i.** ☐ impairment of sight, hearing, or speech
- **j.** ☐ diabetes
- **k.** ☐ anemia

14. Has Proposed Insured 1 or any children named in question 12, ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? *(If yes, explain.)* Yes ◯ No ◯

15. In the last 3 years, has Proposed Insured 1 or any children named in question 12, seen a doctor for any reason not previously explained excluding any routine physical examination with normal findings? *(If yes, explain.)* ◯ ◯

16. Complete for all Applications

Proposed Insured 1 or Applicant, if other than Proposed Insured 1:

	Yes	No	PI 1 Yes	PI 1 No	PI 2 Yes	PI 2 No
a. Do you own any life insurance or annuities on yourself or others?	◉	○				
b. If yes, is this policy a replacement of any of those policies?	○	◉				
c. Is the total amount of insurance in force on you more than $200,000? *(If yes, give amounts and details.)*			○	◉	○	○
d. Is anyone now applying for life or health insurance on you with any other company? *(If yes, in Explanations state company and amounts.)*			○	◉	○	○

Applications (Ages 16 & up): Complete 17-21

	PI 1 Yes	PI 1 No	PI 2 Yes	PI 2 No
17. Have you used tobacco or other nicotine products in any form in the last 36 months? *(If yes, please provide month/year last used: **PI 1** _____ / _____ (Month / Year) **PI 2** _____ / _____ (Month / Year))*	○	◉	○	○
18. In the last 10 years, have you been diagnosed, treated, or been given advice by a member of the medical profession for: *(If yes, explain.)*	○	◉	○	○
19. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? *(If yes, explain.)*	○	◉	○	○
20. In the last 3 years, have you: *(If yes, explain.)*				
a. been convicted of or pleaded guilty to any felony or any moving violations or driving under the influence of alcohol or drugs?	○	◉	○	○
b. engaged in any type of aviation activity (other than as a passenger); or is any such activity planned in the next 6 months?	○	◉	○	○
c. engaged in avocations such as mountain/rock climbing, vehicle racing, SCUBA/skin diving, sky diving, ballooning, or hang gliding; or is any such activity planned in the next 6 months?	○	◉	○	○
21. Do you plan to leave or travel from the United States or Canada in the next 6 months? *(If yes, explain.)*	○	◉	○	○

(Check all that apply)

	PI 1	PI 2		PI 1	PI 2	
a.	☐	☐	cancer or tumor			
b.	☐	☐	diabetes			
c.	☐	☐	heart disease or disorder, chest pain, high blood pressure			
d.	☐	☐	stroke or transient ischemic attack (TIA)			

22. Applicants (Ages 16 & up): Complete 22

Proposed Insured 1 or Applicant, if other than Proposed Insured 1:

	Yes	No
a. Have you entered into or made any plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in the policy you are applying for? *(If yes, explain.)*	○	◉
b. Have you or do you anticipate receiving any type of inducement, fee, or compensation as an incentive to purchase the policy you are applying for? *(If yes, explain.)*	○	◉
c. Have you ever received any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a life insurance or annuity policy? *(If yes, explain.)*	○	◉
d. Have you ever sold, transferred or assigned any life insurance or annuity policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity? *(If yes, explain.)*	○	◉

Applications (Ages 16 & up if NO medical exam is required): Complete 23-26

	PI 1		PI 2	
	Yes	No	Yes	No
23. In the last 5 years, have you applied for or received disability benefits; had an injury to your neck, back, arm, or leg; or had any loss of sight or hearing? *(If yes, explain.)*	○	◉	○	○
24. In the last 10 years, have you been diagnosed, treated, or been given advice by a member of the medical profession for: *(If yes, explain.)*	○	◉	○	○
25. In the last 5 years, have you used cocaine, marijuana, methamphetamine, or any other controlled substance or narcotic not prescribed by a member of the medical profession; had medical treatment or counseling for use of alcohol or prescribed or non-prescribed drugs; or been advised by a member of the medical profession to discontinue use of alcohol or prescribed or non-prescribed drugs? *(If yes, explain.)*	○	◉	○	○
26. In the last 5 years, have you for any reason not previously explained: *(If yes, explain.)*				
a. seen a doctor or psychologist?	◉	○	○	○
b. had medication prescribed **other than** medications for cold, flu, seasonal allergies (i.e. hay fever), or birth control? *(If yes, list and explain.)*	○	◉	○	○
c. had or been advised by a member of the medical profession to have treatment or a test (except for Human Immunodeficiency Virus) in any lab, clinic, or hospital?	○	◉	○	○
d. been told by a member of the medical profession surgery was necessary?	○	◉	○	○

(Check all that apply)

	PI 1	PI 2	
a.	☐	☐	respiratory disorder
b.	☐	☐	liver or intestinal disorder

(Check all that apply)

	PI 1	PI 2	
c.	☐	☐	mental or nervous disorder
d.	☐	☐	blood disorder

27. Explanations:

If space below is insufficient, use additional sheets which will be part of this application. Sheets must be signed and dated by Proposed Insured(s), and/or Applicant, and witnessed by Agent.

[26 a. Annual physical with Dr. William Catner, Bloomington, IL]

28. Agreements

Coverage will be effective as of the Policy Date if the following conditions are met: the first premium is paid when this policy is delivered; the Proposed Insureds are living on the delivery date; and, on that delivery date, the information given to the Company is true and complete to the best of their knowledge and belief.

For changes in Basic Amount for a Universal Life Policy, the change will be effective on the Deduction Date on or next following acceptance of the change by the Company if on such Deduction Date the following conditions are met: there is enough Cash Surrender Value to make the required monthly deduction; the Proposed Insureds are all living; and the information given to the Company is true and complete to the best of their knowledge and belief.

However, if a binding receipt has been given and is in effect, its terms apply.

All Proposed Insureds and the Applicant state that the information in this Application and any medical history is true and complete to the best of their knowledge and belief. It is agreed that the Company can investigate the truth and completeness of such information while this policy is contestable.

By accepting this Policy, the Owner agrees to the beneficiaries named and corrections made. No change in plan, amount, benefits, or age at issue may be made on the Application unless the Owner agrees in writing. Only an authorized company officer may change the policy provisions. Neither the agent nor a medical examiner may pass on insurability.

Any policy issued on this Application will be owned by Proposed Insured 1 or the Applicant, if other than Proposed Insured 1.

I understand that state insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. I understand that I should consult with legal advisors if I have any questions about these matters.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Social Security or Tax Identification Number (TIN) Certification

By signing this application, I certify under penalties of perjury that (1) the TIN shown above is correct, and (2) I am exempt from backup withholding, or that I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding, (*If you are subject to backup withholding, cross out item 2.***) and (3) I am a U.S. person (Including a U.S. resident alien).**

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. (See instructions.)

SAMPLE

Date Signed [May 15, 2010]

at [Bloomington] [IL]
City State

Signature of Proposed Insured 1 X [John Q Doe]

Not required if Proposed Insured is under age 16.

Signature of Proposed Insured 2 X

Signature of Agent as Witness to all Signatures X [Mark Smith]

Signature of Applicant X [Jane C. Doe]

Not required unless applicant is other than Proposed Insured 1. If a firm or corporation is to be the owner, give its name and signature of authorized officer.

State Farm Life Insurance Company
One State Farm Plaza, Bloomington, IL 61710-0001

Doc Type: **01** Check Digit

Application for $10,000 Individual Whole Life Insurance Policy

1. Proposed Insured *(Print name in full)*

[X] Mr [ ] Ms

	Last Name	First Name	Middle Initial
a.	[Doe]	[John]	[J.]

	Mailing Address	City	State	ZIP Code
b.	[123 Main St.]	[Bloomington]	[IL]	[61701]

	Social Security or Tax Identification Number	Sex	Birth Date (mm/dd/yyyy)	Age
c.	[000-00-0000]	[M]	[8/21/1954]	[55]

	Marital Status	Height	Weight	State of Birth	United States or Canadian Citizen?	Yes	No
d.	[Married]	[6 2]	[195]	[IL]		[X]	[ ]

2. Applicant/Owner *(If not Proposed Insured, print name in full)*

	Last Name	First Name	Middle Initial	Social Security or Tax Identification Number
a.	[Doe]	[Jane]	[A.]	[000-00-0000]

	Mailing Address	City	State	ZIP Code
b.	[123 Main St.]	[Bloomington]	[IL]	[61701]

Successor Owner *(Required unless the Applicant/Owner is a **Trust** or **Corporation**)*

	Last Name	First Name	Middle Initial
c.	[Doe]	[Jill]	[A.]

3. Amount of premium submitted with Application: $ [300.00]

Mode of premium payment: [Annual]

4. If the dividend option chosen is not available or no option is chosen, policy provisions determine the option.

[X] Paid-up Additions [ ] Accumulate [ ] Reduce Premium [ ] Cash

5. Do you want the automatic premium loan provision to apply? Yes [X] No [ ]

6. Beneficiary Designation

Primary Beneficiary - Full Name	Relationship
[Jane A. Doe]	[Spouse]

Successor Beneficiary - Full Name	Relationship
[Jill A. Doe]	[Child]

7. Proposed Insured or Applicant, if other than the Proposed Insured:

a. Do you own any life insurance or annuities on yourself or others? Yes [X] No [ ]

b. If yes, is this policy a replacement of any of those policies? [ ] [X]

Questions 8-15: If Proposed Insured answers "Yes" to any of these questions, the Proposed Insured is ineligible and this application should not be submitted.

	Yes	No
8. In the last 36 months, have you been declined coverage or offered a policy with an extra premium by State Farm?	[◯	ⓧ]
9. In the last 36 months, other than basal or squamous cell skin cancer, have you been diagnosed, treated, or been given advice by a member of the medical profession for cancer/tumor or had more than one occurrence of cancer/tumor in your lifetime?	[◯	ⓧ]
10. In the last 36 months, have you been diagnosed, treated, or been given advice by a member of the medical profession for a stroke, heart attack, congestive heart failure, or been advised by a member of the medical profession to have any surgery to the heart or blood vessels, angioplasty/stent, or had a pacemaker installed?	[◯	ⓧ]
11. In the last 36 months, have you been diagnosed, treated, or been given advice by a member of the medical profession for diabetes of any type requiring insulin, been hospitalized for mental or nervous disorder, or used or been advised by a member of the medical profession to use oxygen or any equipment (except CPAP) to assist in breathing?	[◯	ⓧ]
12. In the last 36 months, have you had medical treatment or counseling for use of alcohol, prescribed drugs, or non-prescribed drugs; or been advised by a member of the medical profession to discontinue use of alcohol, prescribed drugs, or non-prescribed drugs?	[◯	ⓧ]
13. Have you ever been diagnosed, treated, or been given advice by a member of the medical profession for any of the following:	[◯	ⓧ]

- ☐ organ transplant
- ☐ amputation due to disease
- ☐ kidney dialysis
- ☐ cirrhosis of the liver
- ☐ ALS (Lou Gehrig's disease)
- ☐ Alzheimer's disease, dementia, or recurrent memory loss
- ☐ installation of defibrillator
- ☐ multiple sclerosis
- ☐ muscular dystrophy
- ☐ Huntington's disease
- ☐ Parkinson's disease

	Yes	No
14. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	[◯	ⓧ]
15. Are you bedridden at home or confined in a hospital, nursing home, or long term care facility?	[◯	ⓧ]

	Yes	No
16. Have you used tobacco or other nicotine products in any form in the last 12 months?	[◯	ⓧ]

17. Explanations:

If space below is insufficient, use additional sheets which will be part of this application. Sheets must be signed and dated by Proposed Insured, and/or Applicant, and witnessed by Agent.

18. Agreements

Coverage will be effective as of the Policy Date if the following conditions are met: the first premium is paid when this policy is delivered; the Proposed Insured is living on the delivery date; and, on that delivery date, the information given to the Company is true and complete to the best of the Proposed Insured's knowledge and belief.

However, if a binding receipt has been given and is in effect, its terms apply.

The Proposed Insured and the Applicant state that the information in this Application and any medical history is true and complete to the best of their knowledge and belief. Information is not true and complete to the best of their knowledge and belief if it misrepresents or omits a fact which a Proposed Insured or the Applicant knew or should have known, regardless whether the misrepresentation or omission was intentional. It is agreed that the Company can investigate the truth and completeness of such information while the policy is contestable.

By accepting this Policy, the Owner agrees to the beneficiaries named and corrections made. No change in plan, amount, benefits, or age at issue may be made on the Application unless the Owner agrees in writing. Only an authorized company officer may change the policy provisions. Neither the agent nor a medical examiner may pass on insurability.

Any policy issued on this Application will be owned by the Proposed Insured or the Applicant, if other than the Proposed Insured.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Social Security or Tax Identification Number (TIN) Certification

By signing this application, I certify under penalties of perjury that (1) the TIN shown above is correct, and (2) I am exempt from backup withholding, or that I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding, (*If you are subject to backup withholding, cross out item 2.***) and (3) I am a U.S. person (Including a U.S. resident alien).**

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. (See instructions.)

SAMPLE

Date Signed [January 15, 2010]

Signature of Proposed Insured X [John J Doe]

at [Bloomington] [IL]
City State

Signature of Agent as Witness to all Signatures X [Mark Smith]

Signature of Applicant X [Jane A. Doe]

Not required unless applicant is other than Proposed Insured. If a firm or corporation is to be the owner, give its name and signature of authorized officer.

SERFF Tracking Number:	*STFL-126339540*	*State:*	*Arkansas*
Filing Company:	*State Farm Life Insurance Company*	*State Tracking Number:*	*43756*
Company Tracking Number:	*SFL1000704*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life_FE Applications*		
Project Name/Number:	*Life_FE Applications/Life_FE Applications*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

See attached Flesch Certification and Regulation 19 certification form for this filing.

Rule & Regulation 49 does not apply to this filing.

Attachments:

ARFLESCH 1000704 1000717.pdf

ARREG19 1000704 1000717.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Two new applications are being filed with this submission; these application forms are attached under the Form Schedule tab.

Item Status: **Status Date:**

Satisfied - Item: Fee Schedule

Comments:

See attached Fee Schedule document for this filing.

Attachment:

AR 1000704 et al Fee Schedule.pdf

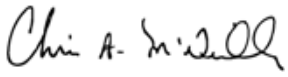
STATE OF ARKANSAS

CERTIFICATE

This is to certify that the attached forms have achieved a Flesch Reading Ease Score indicated below and comply with the requirements of Ark. Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form #	Flesch Score
1000704 AR	50
1000717 AR	39*

When attached to form 07006, the combined Flesch Reading Ease score is 57.



Chris A McNeilly

Assistant Secretary
Title

October 12, 2009
Date

STATE OF ARKANSAS

CERTIFICATION

This is to certify that the forms contained in this submission are in compliance with Arkansas Regulation No. 19:

Form # 1000704 AR and 1000717 AR

Chris A. McNeilly
Assistant Secretary

October 12, 2009
Date

ARKANSAS
INSURANCE
DEPARTMENT
1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: **State Farm Life Insurance Company**

Company NAIC Code: **69108**

Company Contact Person & Telephone # **Rhonda Brackman; ph. 309-766-6896**

Form Number(s): **1000704 AR and 1000717 AR**

****
* INSURANCE DEPARTMENT USE ONLY *
* *
* ANALYST:_____ AMOUNT:_____ ROUTE SLIP:_____ *
****

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing		* x $50 =	
		**Retaliatory	
Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.		* x $50 =	
		**Retaliatory	
Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.	**1000704 AR and 1000717 AR**	*2 x $20 =	**40.00**
		**Retaliatory	**$100.00**
Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms.		* x $20 =	
		**Retaliatory	
Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.		* x $25 =	
		**Retaliatory	

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority.	*	x $400 =	
Filing to amend Certificate of Authority.	***	x $100 =	

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.

**THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.

***THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.